

Nebraska Rural Health Advisory Commission's

Annual Report

of the

Nebraska Rural Health Systems and Professional Incentive Act

December 2012

**Nebraska Rural Health Advisory Commission
September 2012**

Name / Affiliation

Appointment Designation

Commission Chairperson:

Martin L. Fattig, C.E.O.
Auburn, NE

Rural Hospital Administrator

Commission Vice-Chairperson

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Curtis, NE

Rural Mental Health Practitioner

Scot L. Adams, Ph.D., Director
NE DHHS – Division of Behavioral Health
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NE Department of Health & Human Services

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Rural Consumer

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Medical School Representative

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Rural Dentist

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NE DHHS – Division of Public Health
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Designee for Director, Division of Public Health
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Family Practice Resident

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EXECUTIVE SUMMARY

- The Rural Health Systems and Professional Incentive Act, passed in 1991, created the Rural Health Advisory Commission, the Nebraska Student Loan Program and the Nebraska Loan Repayment Program.
- The thirteen (13) members of the Rural Health Advisory Commission are appointed by the Governor and confirmed by the Legislature.
- The Rural Health Advisory Commission's statutory duties include, but are not limited to, establishing state-designated shortage areas, awarding rural student loans and loan repayment to eligible health professionals, and preparing recommendations to the appropriate bodies to alleviate problems in the delivery of health care in rural Nebraska.
- The Nebraska Student Loan Program provides *forgivable* student loans to Nebraska medical, dental, physician assistant, and graduate-level mental health *students* who agree to practice an approved specialty in a state-designated shortage area.
- The Nebraska Loan Repayment Program assists rural communities in recruiting and retaining primary care health professionals by offering state matching funds for repayment of *health professionals'* government or commercial educational debt.
- **The number of rural incentive program recipients is directly proportionate to the state appropriation for the program. The need remains high and the ability to fund loan recipients is declining as shown in Chart 1. The Rural Health Advisory Commission strongly encourages increasing the current state appropriation level for the next biennium (FY2014 and FY2015).**
- As of October 2012, there are 87 rural incentive program recipients practicing under obligation in Nebraska.
- The Nebraska Loan Repayment Program has a 92 percent success rate of recipients completing their practice obligations.
- The Nebraska Student Loan Program buyout rate has dropped from an average of approximately 50 percent in 1998 to the current average of 14%.
- Based on county population, the rural health incentive programs currently impact over 800,000 people living in Nebraska in underserved areas by providing them access to health care professionals.

History

The Rural Health Systems and Professional Incentive Act (the Act) was passed in 1991 creating the Rural Health Advisory Commission, the Nebraska Student Loan Program, and the Nebraska Loan Repayment Program. It should be noted that State of Nebraska employees are not eligible to receive benefits under the rural incentive programs.

Rural Health Advisory Commission

The Rural Health Advisory Commission is a governor-appointed commission consisting of thirteen members as follows: (1) the Director of Public Health of the Division of Public Health or his or her designee and another representative of the Nebraska Department of Health and Human Services; and (2) eleven members appointed by the Governor with the advice and consent of the Legislature. These eleven members include one representative of each medical school located in the state involved in training family physicians, one physician in family practice residency training, one rural physician, one rural consumer representative, one rural hospital administrator, one rural nursing home administrator, one rural nurse, one rural physician assistant, one rural mental health practitioner or psychologist licensed under the requirements of section 38-3114 or the equivalent thereof, and one rural dentist. (*NE Revised Statutes Section 71-5654*)

The purpose of the Commission is to advise the Nebraska Department of Health and Human Services – Division of Public Health, the Legislature, the Governor, the University of Nebraska, and the citizens of Nebraska regarding all aspects of rural health care and to advise the Nebraska Office of Rural Health regarding the administration of the Rural Health Systems and Professional Incentive Act. (*NE Revised Statutes Section 71-5655*)

By statutory authority the Commission has the following powers and duties: (1) advise the Nebraska Department of Health and Human Services – Public Health Division (department) regarding the development and implementation of a state rural health policy; (2) advise the department and other appropriate parties in all matters relating to rural health care; (3) serve as an advocate for rural Nebraska in health care issues; (4) maintain liaison with all agencies, groups, and organizations concerned with rural health care in order to facilitate integration of efforts and commonality of goals; (5) identify problems in the delivery of health care in rural Nebraska, in the education and training of health care providers in rural Nebraska, in the regulation of health care providers and institutions in rural Nebraska, and in any other matters relating to rural health care; (6) *prepare recommendations* to the appropriate bodies to alleviate the problems identified; (7) advise the department regarding the Rural Health Systems and Professional Incentive Act; (8) designate health profession shortage areas in Nebraska; and (9) select recipients of financial incentives available under the Act. (*NE Revised Statutes Section 71-5659*)

Nebraska Rural Student Loan Program

In 1979, the State of Nebraska began awarding low-interest loans to medical students who agree to practice in shortage areas. Due to legislative changes over the years, the Nebraska Rural Student Loan Program now awards *forgivable* student loans to Nebraska medical, dental,

physician assistant, and graduate-level mental health students who agree to practice an approved specialty in a state-designated shortage area. Approved specialties are defined as follows: medical and physician assistant students must agree to specialize in family practice, general surgery, general internal medicine, general pediatrics, obstetrics/gynecology, or psychiatry; dental students must agree to specialize in general practice, pediatric dentistry, or oral surgery; and mental health students must be enrolled or accepted for enrollment in a training program that meets the educational requirements for licensure by the Department of Health and Human Services for “licensed mental health practitioner” or “licensed psychologist”.

The Nebraska Rural Student Loan Program is for Nebraska residents attending graduate college in Nebraska. Student loan recipients receive a forgivable educational loan while they are in training in exchange for an agreement to practice in a state-designated shortage area the equivalent of full-time for one year for each year a loan is received. The number and amount of student loans are determined annually by the Rural Health Advisory Commission based on state funding.

Dental students were added to the Nebraska Student Loan Program in 2000 and graduate-mental health students were added in 2004. In 2000, the Legislature also passed legislation that increased the maximum amount of student loan awards for medical and dental students to \$20,000 per year. The maximum amount of physician assistant student loans was increased to \$10,000 per year. When graduate-level mental health student loans were added in 2004, the maximum amount of a student loan for a doctorate-level mental health student was set at \$20,000 per year and for a master’s level mental health student, it was set at \$10,000 per year. Since 2009, the Rural Health Advisory Commission has awarded student loans at the maximum amount of \$20,000 for doctorate-level students and \$10,000 for full-time master’s level students.

Nebraska Loan Repayment Program

In 1994, the Nebraska Legislature appropriated funding for the Nebraska Loan Repayment Program for health professionals willing to practice in a state-designated shortage area. Initially only physicians, nurse practitioners, and physician assistants practicing one of the defined primary care specialties, clinical psychologists, and master’s level mental health providers were eligible for loan repayment. In 1998, pharmacists, occupational therapists, physical therapists, and dentists were added to the program. The approved specialties are the same specialties defined under the Nebraska Student Loan Program listed previously.

The Nebraska Loan Repayment Program requires community participation in the form of a local match and a 3-year practice obligation for the health professional. Communities must do their own recruiting, using the availability of the loan repayment program as a recruitment and retention tool. Once a health professional is recruited a local entity and the health professional must submit loan repayment applications to the Rural Health Advisory Commission.

State-Designated Shortage Areas

The Rural Health Advisory Commission has the responsibility of establishing guidelines and identifying shortage areas for purposes of the Nebraska rural incentive programs for the primary care specialties defined in the Act. Every 3 years a statewide review of all the shortage areas is

completed. If changes occur in an area during the years between the statewide reviews, the community may request a shortage area designation from the Commission. Any data or information submitted for review is verified by the Nebraska Office of Rural Health and University of Nebraska Medical Center – Health Professions Tracking Services. If the area meets the guidelines for state designation, the Commission will designate it.

Criteria for the federal and state designations differ and are used for different federal and state programs. Nebraska Office of Rural Health staff can assist with the data requirements and benefits of the various shortage area designations and incentive programs. Guidelines for the state-designated shortage areas and the current federal and state shortage areas are posted on the Nebraska Office of Rural Health webpage.

While the Nebraska rural incentive programs primarily focus on *rural* shortage areas Federally Qualified Health Centers (FQHCs) may request to be designated as state-designated shortage areas for family practice and/or general dentistry. As a state-designated shortage area, FQHCs may then qualify for benefits under the state incentive programs in addition to *federal* health professional incentive programs.

The Nebraska Office of Rural Health works to maximize state funds for areas not eligible for the benefits under the federal incentive programs due to practice area or practice specialty eligibility. Health professionals who are eligible are encouraged to apply first for the National Health Service Corps (NHSC) Loan Repayment Program before applying for the Nebraska Loan Repayment Program. Due to the recent reduction in funding and the use of Health Profession Shortage Area scoring for the federal NHSC Loan Repayment Program, health professionals practicing in Nebraska FQHCs are finding it difficult to be accepted in the federal loan repayment program. This has led to an increase in the number of health professionals applying for the Nebraska Loan Repayment Program which has created a waiting list for loan repayment due to more demand for the limit state funds.

Analysis of the Rural Incentive Programs

Chart 1 on page 7 shows graphically the number of rural incentive recipients by program receiving payments by fiscal year. Several factors influence the number of incentive recipients each year. These factors include the amount of state funds available, the amount of each individual incentive award, and the educational level of the recipients. FY2012-13 is based on signed contracts as of November 1, 2012 with more awards to be approved by the Rural Health Advisory Commission as long as state funds are available. As one commission member stated, *“of all the programs, these are the most successful and the money comes back many times over.”* The demand for the rural incentive programs remains high while the ability to fund awards is declining.

Chart 2 on page 8 shows the budget amounts by source for each fiscal year. Comparing Charts 1 and 2 demonstrates the increase in FY2008-09 of recipients and budget. In FY2008-09 the Legislature increased the rural incentive program budget by \$250,000 per year for 4 years. This funding increase was from the Merck Settlement in the form of cash. The Legislature provided for the use of \$250,000 from the Merck Settlement each of four years for the state match for loan

repayment and \$250,000 per year in “cash spending authority” for the local match funds required for the Nebraska Loan Repayment Program.

Beginning in FY2009-10, the Rural Health Advisory Commission began awarding student loans and loan repayment at the maximum levels of \$20,000 or \$10,000 per year depending on the educational level of the recipient. This resulted in fewer awards but assisted rural communities in being able to compete with larger communities to recruit and retain health professionals.

Chart 3 on page 9 shows the dollar amount of rural incentive awards by program by fiscal year. Student loans are awarded by the Rural Health Advisory Commission in June prior to the beginning of each fiscal year; therefore student loans have not been awarded yet for FY2013-14.

Loan repayment awards are made at each Rural Health Advisory Commission meeting as applications are received and state funds are available. Loan repayment requires a 50-50 local-state match and cash spending authority to spend the local match. Loan repayment awards will continue to be made during FY2012-13 as long as state funds are available and eligible applications are received.

Chart 4 on page 10 gives another perspective to the loan repayment awards. Since loan repayment requires a 50-50 state-local match, Chart 4 shows the funding impact of loan repayment awards by fiscal year. The increase “bump” beginning in FY2008-09 is the addition of the Merck Settlement cash funds. The slight “dip” in FY2009-10 and FY2010-11 is the impact of the Rural Health Advisory Commission’s decision to increase the loan repayment awards to the maximum amounts to remain competitive in the market.

The Nebraska Loan Repayment Program requires a 3-year practice obligation so when the Rural Health Advisory Commission awards loan repayment the obligation of funds is projected over the 3-year practice obligation. Loan repayment awards being made in FY2012-13 will impact the rural incentive program budget in FY2013-14, FY2014-15, and FY2015-16; hence the future budget obligations shown on Chart 4.

Charts 5 and 6 on pages 11 and 12 show the number of recipients by profession by fiscal year for the Nebraska Loan Repayment Program and Nebraska Student Loan Program; respectively. The Commission believes that the Nebraska Student Loan Program has been a good program for dental students interested in rural practice. Unlike the Nebraska Loan Repayment Program, dental student loan recipients do not have to find a local agency to match the state loan repayment funds and they can be self-employed and still receive forgiveness of their rural incentive student loans. More medical professionals, physicians, physician assistants, and nurse practitioners, use the loan repayment program than any of the other health professionals eligible for loan repayment.

Table A on page 13 shows the number of student loan awards issued each year from FY2003-04 through FY2012-13. Since FY2003-04, the Rural Health Advisory Commission has awarded an average of 7 new student loans and 10 continuation student loans per year.

Prior to 1998, buyout rates for student loans, historically, averaged about 50 percent. Given four years of medical school and at least three years of residency training, a medical student loan recipient will not be available to practice in a shortage area for up to seven or more years. To improve the success rate of recipients fulfilling their practice obligations, administrative changes were implemented in 1998 to remind student loan recipients of their practice obligation. Then in 2007, the Rural Health Advisory Commission recommended a legislative change to reduce the buyout rate for student loan recipients from 24% simple interest from the date the loan was received to 150% of the principal plus 8% at the time of default. During the most recent 5-year period (FY2004 – FY2008), for which data are available, the buyout rate has dropped to an average of 14%.

Table B on page 14 provides a summary of the Nebraska Loan Repayment Program from 1994 through 2012. Since 1994, 416 health professionals have participated or are participating in the Nebraska Loan Repayment Program. Seventy-two percent (72%) of loan repayment recipients have completed their practice obligation. Less than 8% of loan repayment applicants have defaulted on their practice obligation. As of November 2012, there are 78 *loan repayment* recipients in practice under obligation in rural or underserved areas of Nebraska with more to be added as contracts are signed.

The map on page 15 shows the practice location of rural incentive recipients as of October 2012 and includes the Legislative District outlines. At that time 87 licensed health professionals were in practice under obligation.

Highlights of the Rural Health Advisory Commission's Recommendations

Each year the Rural Health Advisory Commission – Policy Committee reviews and prepares recommendations to assist in alleviating problems in the delivery of health care, in the education and training of health care providers, in the regulation of health care providers and institutions, and in any other matters relating to rural health care in Nebraska. The 2012 Summary of Recommendations for Enhancement of Health in Rural Nebraska includes the following focus areas:

1. Incentive Programs for Rural Health Professionals;
2. Behavioral Health Services;
3. Integrated Service Delivery and Training Systems;
4. Rural Emergency Medical Services;
5. Rural Communication and Information Technology Systems;
6. Rural Quality;
7. Strengthening Rural Health Services by Improving Access to Affordable Health Care;
8. Rural Managed Care and Reimbursement; and
9. Veterans Care.

In the 2012 recommendations report, the Commission identified the needs within each of the focus areas and support for each of the recommendations. The 2012 Summary of Recommendations for Enhancement of Health in Rural Nebraska report is attached as Appendix A beginning on page 16.

Summary

As a result of both the rural incentive programs, as of October 2012, there are 87 licensed health professionals in practice under obligation providing access to health care services for over 800,000 people¹ living in Nebraska. These two rural incentive programs (student loans and loan repayment) are the only state-funded programs of this type to encourage health professionals to practice in state-designated shortage areas. The only limitation to these programs is the level of the state appropriation.

¹ Based on county populations.

CHART 1
Nebraska Rural Incentive Programs
 Number of Recipients Receiving Payments by Program by Fiscal Year

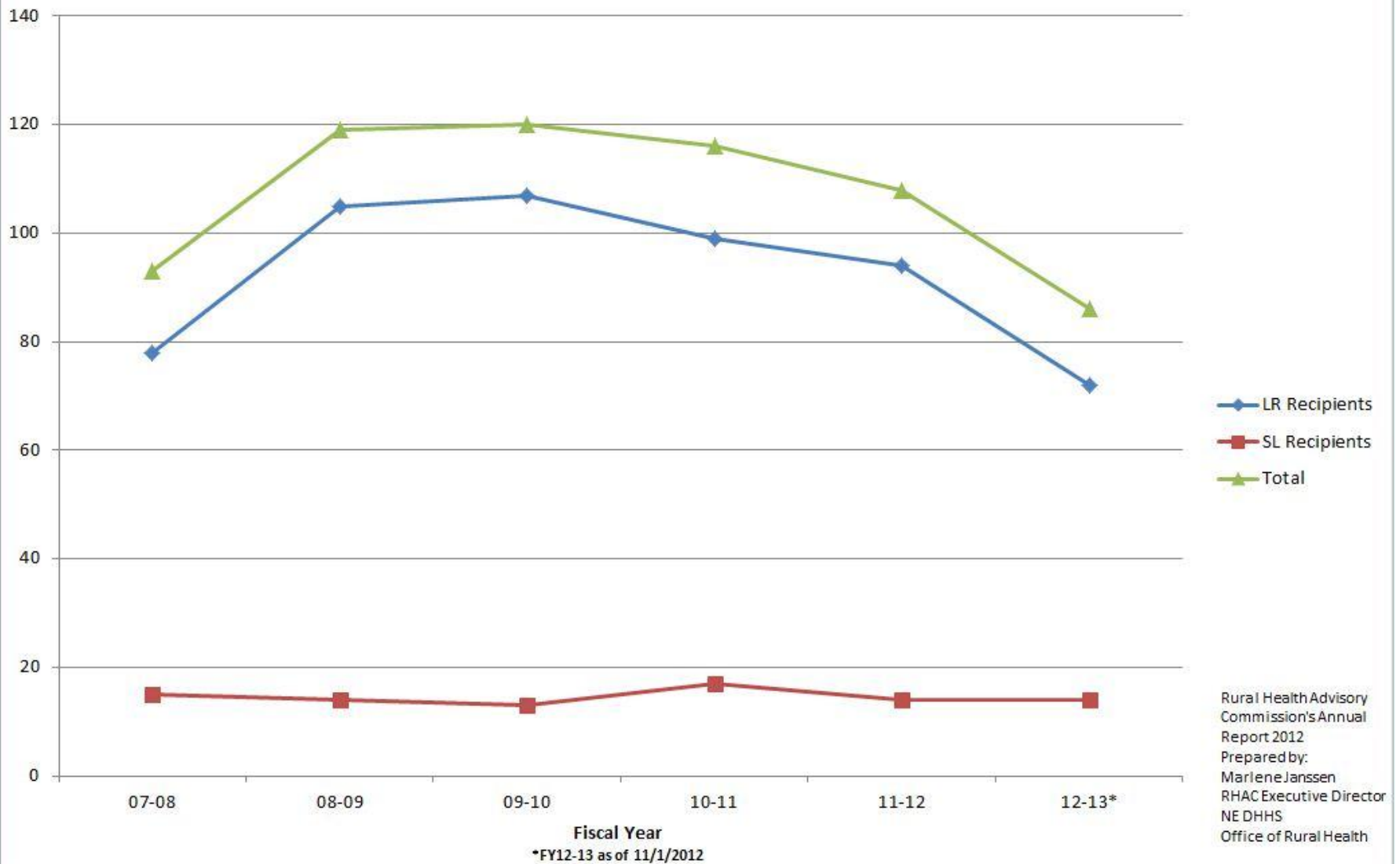


Chart 2
Nebraska Rural Incentive Programs
State Budget Appropriation By Source By Fiscal Year

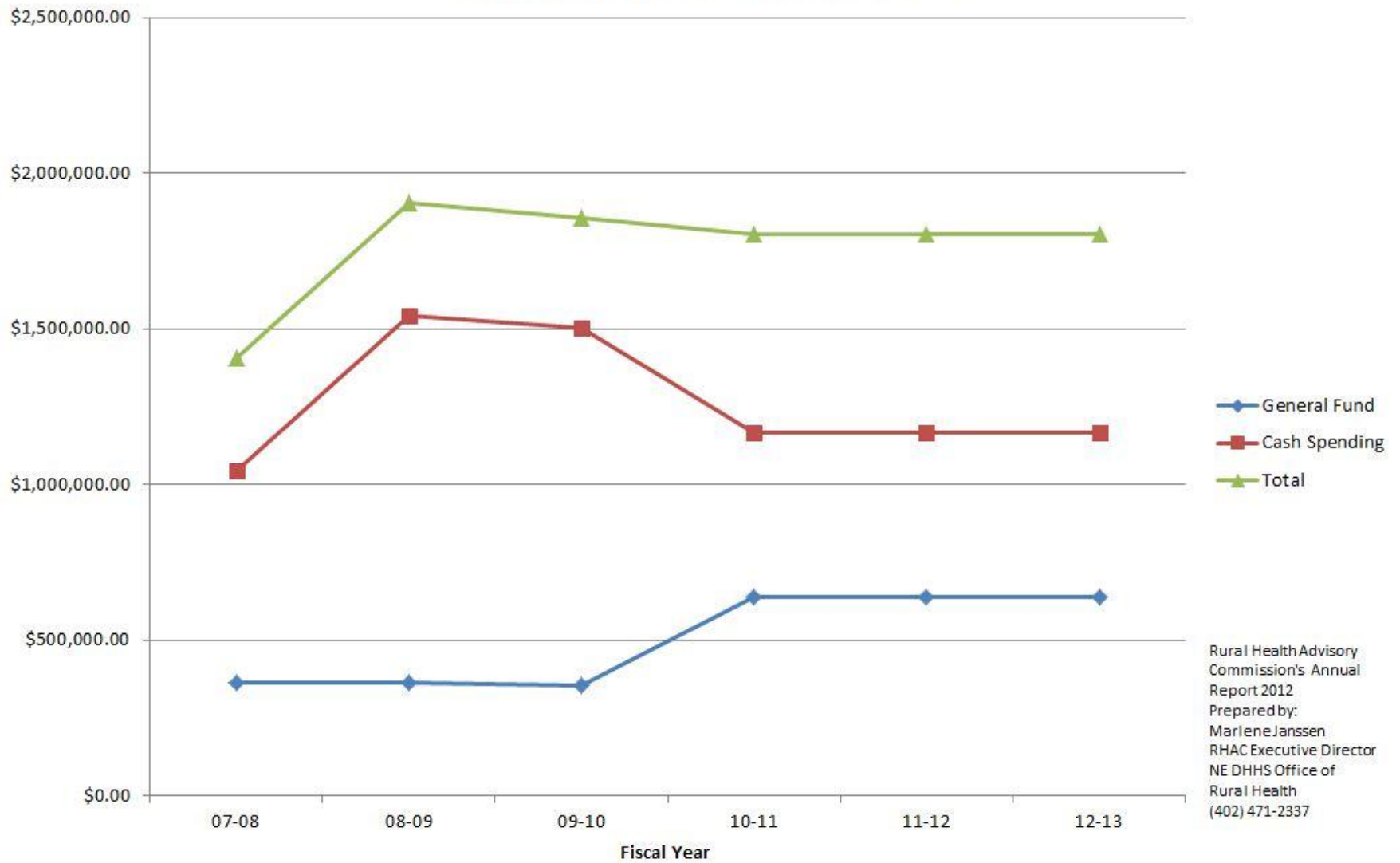


CHART 3
Nebraska Rural Incentive Programs
\$ Amount of Rural Incentive Awards by Program by Fiscal Year

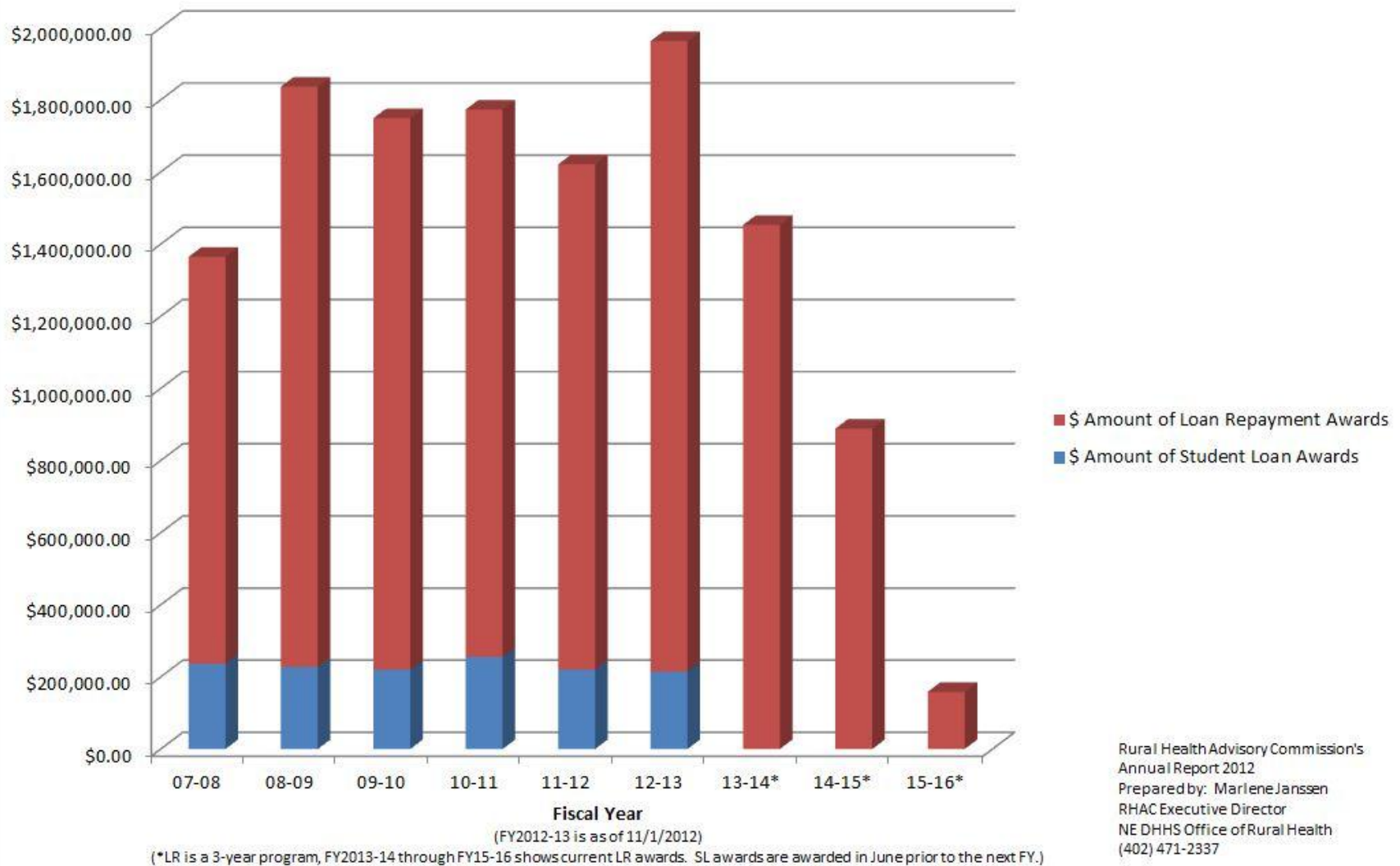
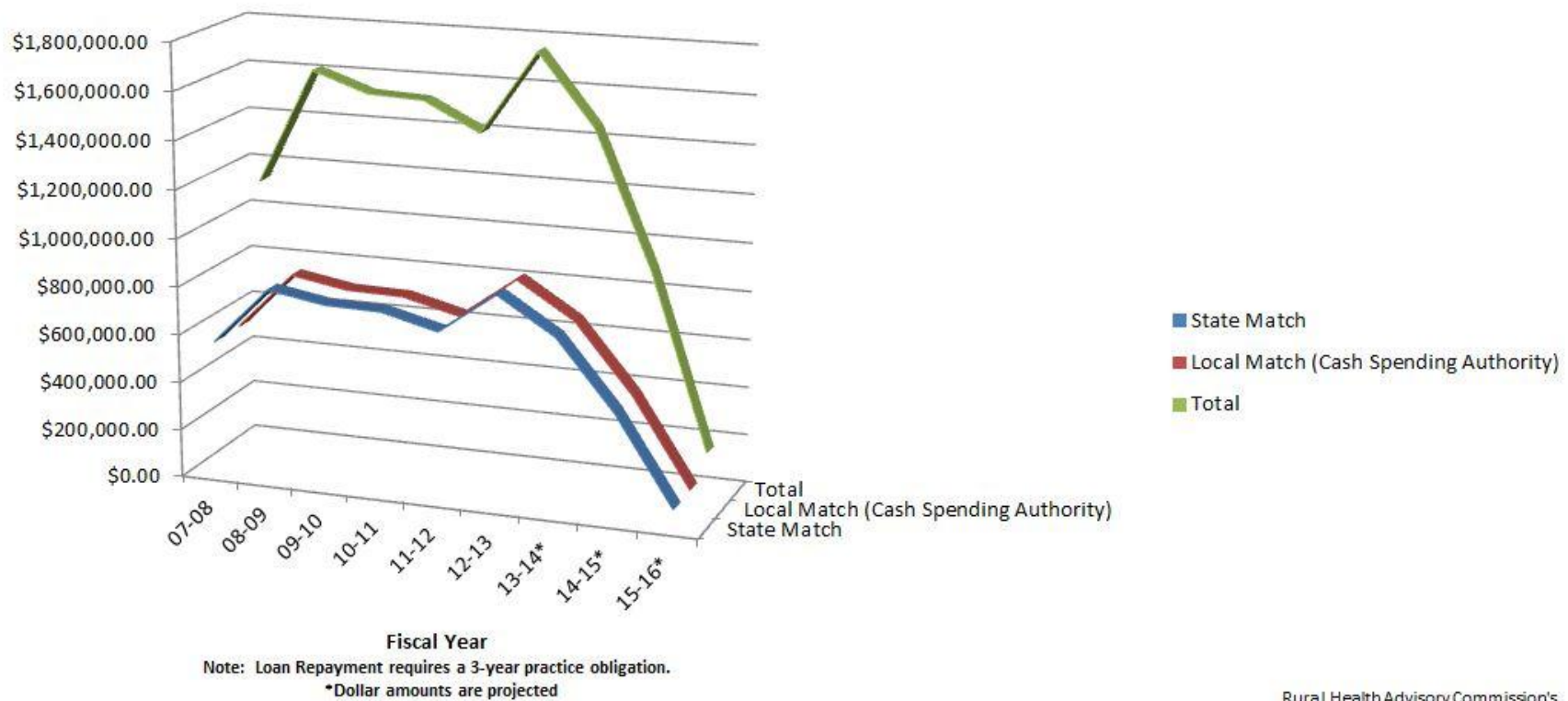


CHART 4
Nebraska Loan Repayment Program
\$ Amount of Awards by Contribution Source by Fiscal Year
 (Note: Loan Repayment requires a 50-50 State & Local Match. Cash Spending Authority is needed for the Local Match)



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CHART 5
Nebraska Loan Repayment Program
Awards by Profession by Fiscal Year

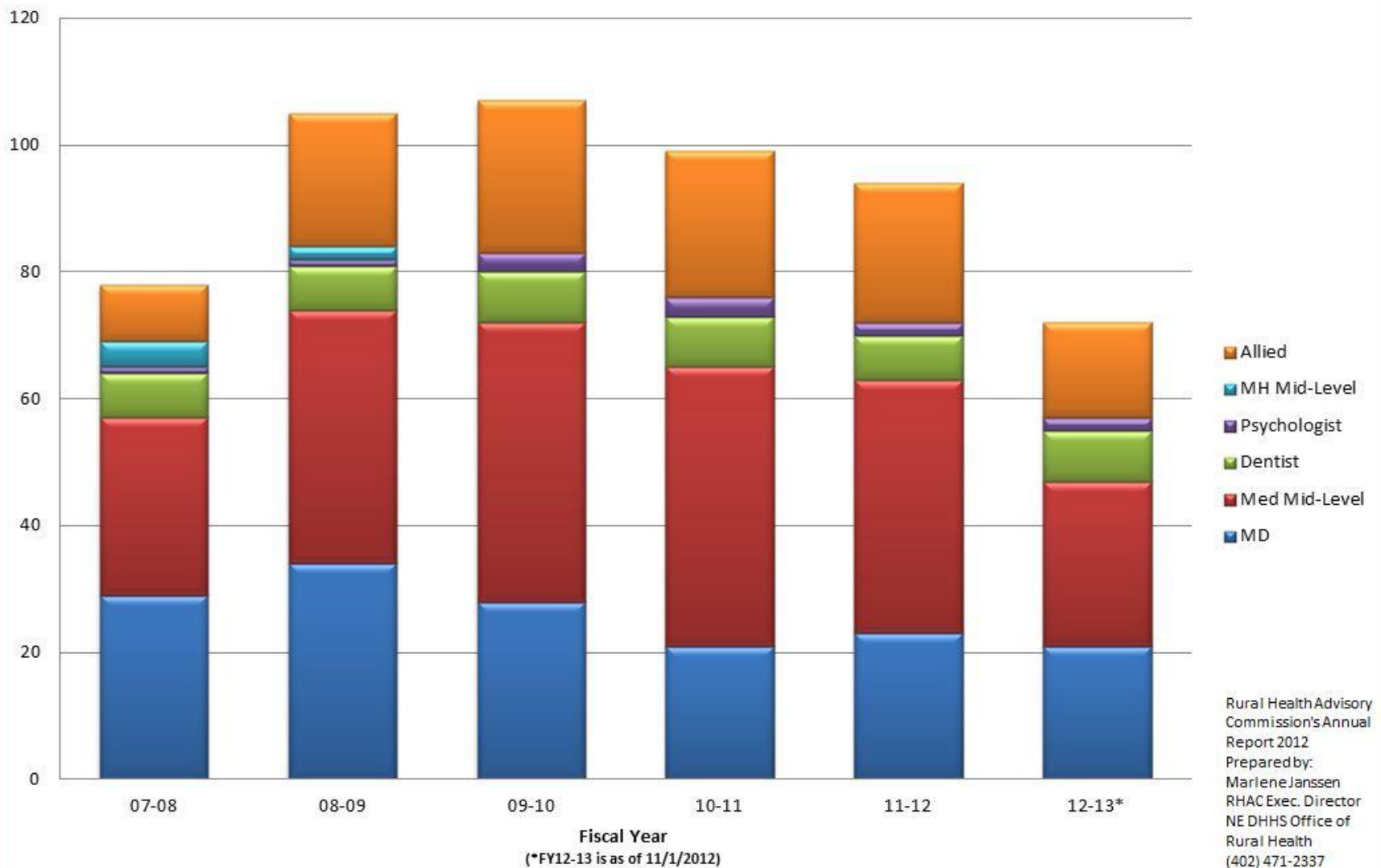


CHART 6
Nebraska Student Loan Program
 Student Loan Recipients by Profession by Fiscal Year

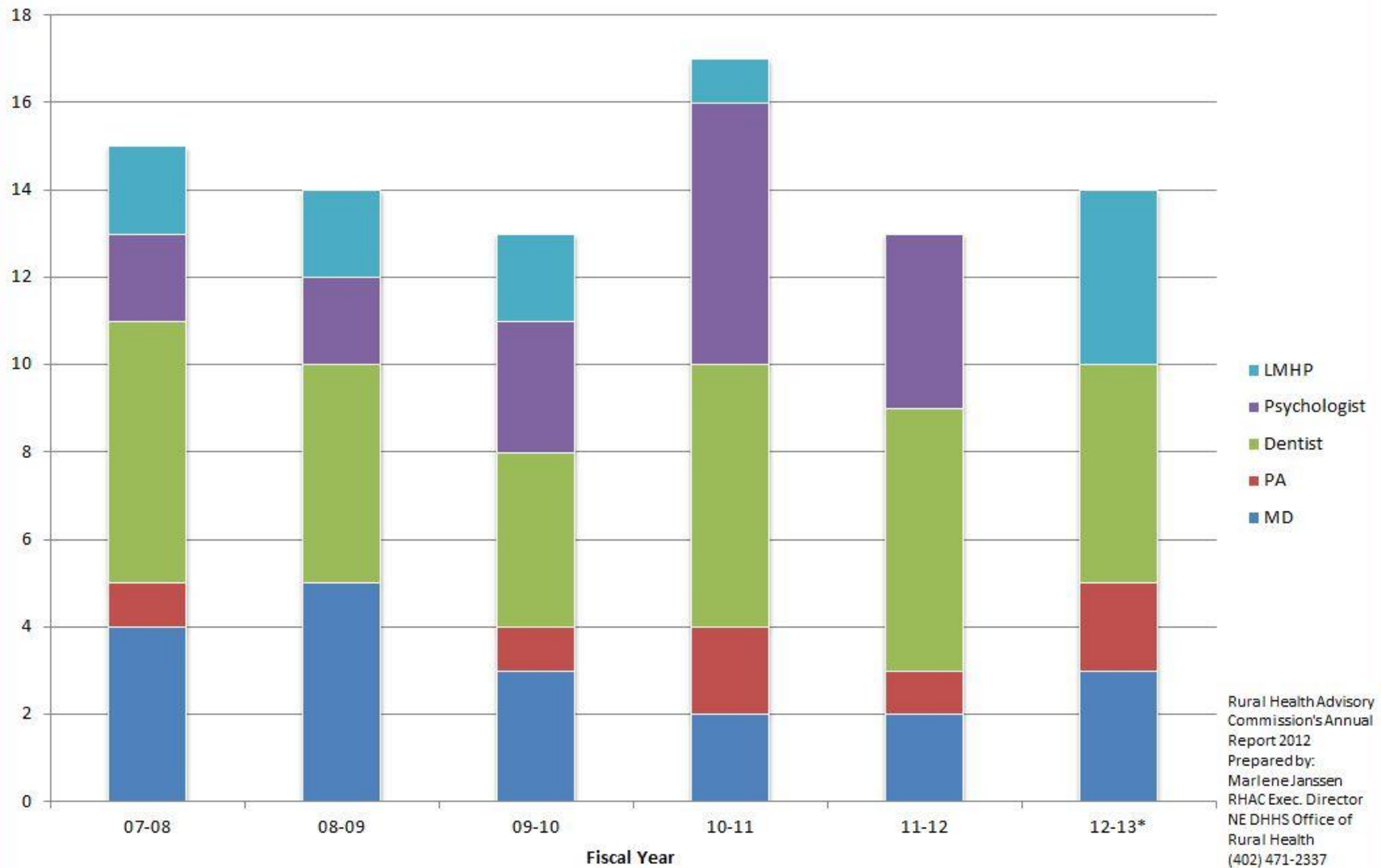


TABLE A
Nebraska Rural Student Loan Program
Number of Student Loans by Type & Outcome By Fiscal Year
(Duplicate Counts (1))

Fiscal Year	Total Amount Awarded	Student Loan Awards			In Training As of 2012 (2)	Outcomes As of 2012				
						In Practice Forgiveness	Completed Practice	Partial Forgiveness/ Buyout	Contract Buyout	Buyout Rate (3)
		New	Continuation	Total						
2003-04	\$255,000	6	11	17	0	1	11	3	2	11.8%
2004-05	\$292,000	12	10	22	0	2	15	3	3	13.6%
2005-06	\$341,250	10	14	24	0	5	14	2	3	12.5%
2006-07	\$341,250	6	16	22	1	6	6	2	4	18.2%
2007-08	\$236,250	6	9	15	2	7	2	2	2	13.3%
2008-09	\$227,500	7	7	14	6	5	1	NA	2	NA
2009-10	\$220,000	6	7	13	9	3	NA	NA	1	NA
2010-11	\$255,000	7	10	17	13	3	NA	NA	1	NA
2011-12	\$220,000	6	8	14	13	1	NA	NA	NA	NA
2012-13	\$215,000	8	6	14	14	NA	NA	NA	NA	NA
								5-Year Average Buyout Rate		14.0%

Footnotes:

1. Student Loan recipients may receive up to four annual loans. This means a recipient will be counted as “New” the first year and then as “Continuation” in subsequent years. Summing the “Total” student loan awards over several years will result in duplication of individuals receiving awards.
2. “In Training” means in school, residency, or provisionally licensed.
3. “Buyout Rate: is the number of recipients who buyout their contracts without ever practicing a primary care specialty in a shortage area divided by total student awards for each year. Buyout rates are not applicable for 2008-2012 since most recipients are still in training.

Historical Notes:

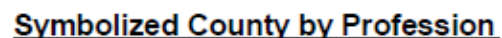
- In 2000, dental students became eligible to apply for the Nebraska Student Loan Program. The maximum student loan award amount was increased to \$20,000 per year.
- In 2004, graduate-level mental health students became eligible for the Nebraska Student Loan Program.
- In 2009, the rural Health Advisory Commission began awarding student loans at the maximum amounts per year: \$20,000 for doctorate level students and \$10,000 for full-time master’s level students.

TABLE B

Nebraska Loan Repayment Program
Number of Awards by Status
1994-2012

Status	Awards
In Practice Under Obligation FY2012-13	78
Completed Practice Obligation	301
Default	33
Other	4
Total	416

*Student Loan and Loan Repayment Participants by County
[87] Obligated Healthcare Providers as of October 2012*



56

12

14

⑤

Logic

Map created by Terrence Lage, Office of Rural Health
Created for Marlene A. Janssen, Executive Director, Rural Health Advisory Commission
marlene.janssen@nebraska.gov | DHHS - Office of Rural Health

APPENDIX A

Rural Health Advisory Commission's 2012 Summary of Recommendations for Enhancement of Health in Rural Nebraska

EXECUTIVE SUMMARY

The Nebraska Rural Health Advisory Commission's Vision Statement is:

"All rural Nebraskans have access to a dynamic, integrated health and health care system meeting all of their physical and mental health needs."

Each year the Nebraska Rural Health Advisory Commission drafts a set of recommendations to address present and future health and health care access issues. The Commission studies the national, state and local community issues and recommendations before creating a list of recommendations that they believe policy makers and stakeholders should be discussing and acting upon. The recommendations include:

1. Incentive Programs for Rural Health Professionals: The Nebraska models have been very successful at placing rural health professionals in rural and medically underserved areas of the state. A funding loss of \$250,000 will occur unless those funds are replaced by the same amount of general funds beginning in 2012. (These funds were from the Merck drug settlement with the State.)
2. Behavioral Health Services: Many issues are driving the need to seriously address the growing shortage of mental and behavior health providers. Demographics, returning veterans, aging, economy and other stressors can be seen in our state. Training, recruitment, and retention of needed health professionals must be addressed.
3. Integrated Service Delivery and Training Systems: systems of care delivery are changing rapidly and rural Nebraska may be at risk because of some of the proposed change models. With a shortage of primary care health providers, there is a great need for integration of care models and the need for these professionals to be trained in integrated training models.
4. Rural Emergency Medical Services: Nebraska has 424 ambulance agencies for 524 incorporated communities. Eighty percent (80%) of these are volunteer services and aging and ambulance expenses are taking their toll on some of the smaller services. There is a need for the State to designate a responsible entity (regulatory or oversight body) to lead the transformation to a more sustainable emergency medical system for our state. This would also include the need to standardize care models for services being delivered.
5. Rural Communication and Information Technology Systems: rural health providers need to have quality broadband and other telecommunication systems to help them meet the access to care issues. Models need to be financially sustainable and subsidized as needed to ensure use and quality service delivery or evaluation.
6. Rural Quality: rural health advocates from across the state and nation must provide the voice in any health care delivery and/or payment discussions. New, out of the box, partnerships should be developed to address the payer and patient quality demands.

Rural Health Advisory Commission's 2012 Summary of Recommendations for Enhancement of Health in Rural Nebraska

The Nebraska Rural Health Advisory Commission's vision statement is:

All rural Nebraskans have access to a dynamic, integrated health and health care system meeting all of their physical and mental health needs.

In the face of the changing local, state, and national health care environment, the Nebraska Rural Health Advisory Commission has drafted the following 2012 recommendations for the Governor, the Legislature, the Nebraska Department of Health and Human Services, and the citizens of our State.

Each year, the Rural Health Advisory Commission considers the immediate and future access to health care issues that our state's rural communities are or will be facing. We focus on our communities because we believe that our communities matter to their citizens and to all of us who live in this State. One of the most important matters that every community must address is the health and health care accessibility for their residents.

The number of primary care providers in the State continues to decrease despite the State's increasing need. These needs are even more prevalent in our rural areas, where providers must do more with fewer resources and support than their urban counterparts. Many health care providers begin their educational journey with the dream of returning to the rural areas in which they were raised. Sadly, this goal many times remains unattained due to the many difficulties facing providers in rural areas. Lower reimbursement and longer hours are there to rudely greet the new rural provider, along with ever increasing levels of student debt. The rural health incentive programs serve to eliminate one of the major barriers in retaining and attracting young providers to return to their underserved rural areas. These programs play a vital role in providing continued access to healthcare in some of the most rural areas of the State. With a default rate of less than 9% (meaning that 91% of recipients fulfill their obligation to practice in a rural or underserved area), the tremendous success of these programs is instantly recognizable.

"Student debt has been increasing at a rate much higher than inflation, and many graduates are facing huge debt loads of greater than \$200,000. As recently reported, total student debt in this country now amounts to more total dollars than America's total credit card debt! This alone is swaying people away from primary care medicine in general, regardless of practice location. The student loan repayment programs not only serve to place providers in rural and underserved areas, but also help in attracting students to pursue primary care fields from the very beginning of training. If I am honest, I must question whether I myself, would have chosen primary care without the reassurance of these types of loan repayment programs. Along with my fellow classmates, I have begun to look for the practice location where I can make the greatest contribution to my home state. Many of us have roots in small, rural towns, and have turned back to those roots, because of the sense of home they provide. The loan repayment offered by these programs allows all of us who have ever had a dream of returning to a small rural community as a family practitioner, the opportunity to do so without the burden of mounting debt." – Zach Frey

The following recommendations have been crafted from that perspective and with the knowledge that it will take partnerships between communities, between communities and their governments, between communities and their health professionals, and all of the other partners who have a stake in the rural places and people of our State. The issue is *access* to health and health care, and we respectfully ask your partnership in helping our rural communities to have that access.

The Rural Health Advisory Commission, therefore, recommends the following:

I. Incentive Programs for Rural Health Professionals

- A. The Rural Health Advisory Commission (RHAC) strongly advocates for maintaining financial support of the state's incentive programs (student loans and loan repayments) for statute identified rural health professionals. (2011 was the last year of the Merck Settlement cash of \$250,000.) The Commission also supports the continued assessment of health care provider shortages, especially primary care physicians listed in the Rural Health Systems and Professional Incentive Act: family practice and general surgery, physician assistants, pharmacists, advanced practice nurses, dentists, licensed mental health professionals (LMHPs), psychologists, psychiatrists, and physical and occupational therapists. We also support alternative incentives to remove barriers in recruitment and retention of these health care providers. Since 1994, 401 health professionals have or are participating in the Nebraska Loan Repayment Program with over 91% completing their practice obligation.
 1. a. The Commission encourages the continued support, utilization and enhancement of the present rural health incentive programs managed by the Nebraska Office of Rural Health.
 - b. The Commission strongly encourages maintaining the current state appropriation level for the coming biennium budget for the incentive programs (student loans and loan repayments). (This would mean replacing the Merck \$250,000 amount with state funding.)
 2. a. The Commission recommends that affected/invested stakeholders participate in health care workforce studies and meet with, or communicate to, the Commission a review of their findings; and then to work at the creation of an encompassing strategy and work plan to address identified workforce shortages.
 - b. The Commission supports the development and operation of the Nebraska Healthcare Workforce Center that would be the trusted source of data related to current and future workforce shortages so that proactive solutions to resolving the shortages could be developed.

II. Behavioral Health Services:

The RHAC is deeply concerned about the present and future status of behavioral health care in rural Nebraska. Major issues needing to be addressed include the continuing shortage of community based behavioral health providers. While the state incentive programs have been

successful in placing a certain number of mental health providers in rural areas, there continues to be a strong need for additional placements. The Commission also recognizes the importance of retaining providers who are presently serving rural areas and supports the development of resources and reimbursements to assure their retention. The Commission supports an integrated health delivery system that addresses both medical and mental health needs/resources.

A. Community based mental health workforce issues should be addressed through:

1. Maintaining funding for current state incentive programs for behavioral health workers including:
 - a. supporting legislative efforts to maintain and strengthen present programs;
 - b. assessing and developing alternative funding sources; and
 - c. working with existing workforce development programs and resources.
2. Addressing provider payment incentives to encourage professionals to locate and practice in rural areas.
3. Evaluating present provider payment issues and developing recommendations to update present payment models.
4. Supporting an integrated model of care utilizing present mental health/behavioral health providers in new roles and systems.

B. Medicaid reimbursement for behavioral health providers in rural areas needs to be addressed through:

1. Reasonable reimbursement incentives for behavioral health providers practicing in rural areas.
2. Support and update payment reimbursement models for unique rural issues including:
 - a. transportation and travel costs;
 - b. supervision reimbursement;
 - c. payment reimbursements for integrated services; and
 - d. payment issues to support the use of telehealth services
3. Evaluating present Medicaid reimbursement issues and offering recommendations, as appropriate.

III. Integrated Service Delivery and Training Systems

The Rural Health Advisory Commission supports the creation of a sustainable reimbursement model to help advance integration. In order to meet the demands of the Affordable Care Act, in its current form, healthcare providers of all types will need to form integrated networks, both formal and informal, to survive. Such healthcare delivery models, as Accountable Care Organizations, bundled payments, pay for performance and the Medical Home will require the integration of providers in ways that are new to everyone. In order to meet the demands

required by these and future new healthcare delivery models, Nebraska providers, both rural and urban, will need to be prepared to meet the organizational system demands as they become known. In addition, they must also address the demographic shifts that are happening.

- A. The Commission encourages and supports the development of an integrated, networked system of basic physical and mental/behavioral health care, and the reimbursement model needed to sustain it.
- B. The Commission encourages all in-state health professional education programs to include training experiences in rural areas to assist providers in understanding the delivery of medical and mental health care challenges in a rural community.
- C. The Commission believes the rural primary health care provider system(s) are, and will continue to experience, a shortage in allied health professionals. Therefore:
 - 1. The Commission encourages the NE DHHS, the Nebraska Office of Rural Health and Primary Care Office, and appropriate associations to research the limitations of present utilization models for allied health professionals in rural areas, and create a set of priorities and strategies to address those deficiencies.

IV. Rural Emergency Medical Services

The Commission believes in the maintenance of a strong traditional emergency medical services (EMS) system and in exploring new ways in which unmet needs can be met utilizing present resources.

- A. The Commission supports the Legislature's efforts to designate a responsible entity (such as a regulation and oversight body) at the state and local levels for EMS development, implementation and operation. The Commission supports new utilization models, that will lead to a new standardization of care model for all stakeholders.
- B. The Commission recommends new EMS training models that incorporate the use of telecommunications through integrated hospital networks and emerging Rural Health Information Exchanges.

V. Rural Communication and Information Technology Systems

The Commission encourages the continued improvement and training in the use of communication technology within the rural communities. This includes a review of needs for adequate rural broadband and wireless accessibility, the training needs of present and future health care providers using this technology, and the local linkages to specialized care for our rural citizens.

- A. The Commission recommends that the Nebraska Department Health and Human Services work with advanced rural telehealth network models to identify best practices that can be duplicated in other areas of the state.

- B. The Commission strongly encourages the use of telecommunications for consultations, education, and electronic health information delivery to and from homes, hospitals and other health care providers.
- C. The Commission recommends development of strong telecommunications linkages between public health departments, area hospitals, and other health professionals to address district-wide, regional, and statewide health needs.
- D. The Commission supports the use of electronic health record (EHR) technology by all healthcare providers and the secure sharing of patient information through health information exchanges. Even though some of these exchanges have already been developed, alternative systems need to be explored to ensure that the best systems are in use and that those systems are designed in such a way that the business model that funds them is truly financially sustainable.
- E. The Commission strongly encourages the use of standardized protocols for all reporting, transmitting and the exchange of all healthcare data.
- F. The Commission also recommends that state agencies develop the capacity to receive important patient information that certified EHRs are required to transmit.

VI. Rural Quality

The Rural Health Advisory Commission supports efforts to improve the quality of health care provided in rural areas. The Institute of Medicine (IOM) report entitled, “Quality through Collaboration: The Future of Rural Health” outlines an excellent agenda for achieving this goal. The Affordable Care Act (ACA) also calls for the development of a National Healthcare Quality Strategy to be developed. This strategy may have a significant impact on the quality efforts of all providers, especially those in rural areas. The Commission believes that Nebraska is in a position to be a leader in the implantation of this agenda, once it is defined. It also supports the efforts of healthcare providers (physicians, health departments, home health, Advance Practice Nurses, dentists, mental health providers, etc.) to join the Nebraska Coalition for Patient Safety and participate in the reporting of adverse events and “near misses” as defined by the Coalition as reportable events

- A. To achieve this higher quality standard, the RHAC will:
 - 1. Testify and provide additional information to the Legislature and appropriate subcommittees about the need for health care delivery changes.
 - 2. Identify the additional primary care needs/solutions for the next 10 years in all health care professions. (To provide satisfactory health care to rural Nebraska residents.)
 - 3. Promote continued research into utilizing, developing, and applying rural healthcare models in rural health settings.

B. Recommendations:

1. Encourage developing partnerships with local businesses to provide health care clinics for the underserved, uninsured, under insured, chronic illness cases, and returning war veterans.
2. Encourage and support Universities and Colleges in establishing rural residency programs within rural health care systems. Rural residency programs should include medical, nursing, dental, mental health, pharmacy, business schools, public health, occupational health, rehabilitation students and other graduate schools that contribute to rural health.
3. Encourage apprenticeship/internships in collaboration with health clinics in rural areas from business, public health, law, information technology (IT), and marketing students.
4. Encourage and provide financial incentives to support Telehealth medicine.
5. Encourage and provide financial incentives for rural healthcare providers to continue involvement in Quality Improvement Organization programs.
6. Promote and reward broader case management concepts that increases Registered Nurse services for the underinsured, uninsured, vets, etc. in rural Nebraska.

VII. Strengthening Rural Health Services by Improving Access to Affordable Health Care

Many additional health disparity issues continue to be found in our rural communities. The recruitment/retention of providers, the maintenance of facilities, loss of population, and the cost of care/drugs for lower income patients are but a few issues facing rural Nebraska.

A. The Commission recommends:

1. The creation of a new, proven, payment template for an integrated networked service model. (This totally integrated model should be designed to help providers transition from trials to successful integration.)
2. Review of the opportunities for Nebraskans to obtain healthcare insurance coverage through the Health Insurance Exchanges created by the national health reform legislation. Careful consideration needs to be given to the decision that creates a state insurance exchange or depend on one created at the federal level for our state. How will rural Nebraska be best served?

VIII. Rural Managed Care and Reimbursement

The Commission believes that reimbursements of health services provided drive the successful models for health care delivery within our state; therefore:

- A. The Commission supports the development of a Medicaid rural “Primary Care Team” model, with attractive reimbursement, for those providing all primary care services to rural communities (Medical, Dental, Behavioral Health, etc.).
- B. The Commission recommends that all Nebraska Department of Health and Human Services’ fund potential new rural care delivery models and assist with a rural impact study to identify outcomes.

IX. Veterans Care

The majority of soldiers returning from the wars come from our rural communities, which often lack the needed professional healthcare providers to assist them with the many injuries they may have received. Steps must be taken to make sure that these soldiers, who have served their country so well, are able to receive the care they need and deserve as close to their home as possible.

Issues to be included may be:

- A. The Rural Health Advisory Commission recommends the creation of a State, Veterans Affairs, National Guard, and health provider association council to address veterans (and their families) health care in rural Nebraska.
- B. Meeting the mental health needs of the returning veterans must be given the same consideration as meeting their physical needs.
- C. Work with Veterans Administration to allow veterans to receive chronic/long term care in local communities.